STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676105	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interviews and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of the resident for 1 of 7 (Resident #1) residents in that: The facility failed to ensure Resident #1 was treated with respect, dignity, and care when they failed to obtain clear informed consent on 8/11/2024 at approximately 3:30 AM, to perform a straight catheter procedure to collect a urine sample. An Immediate Jeopardy (IJ) situation was determined to have existed on 8/11/24. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance on 8/19/24 and updated 9/4/2024 prior to the beginning of the survey. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth, psychosocial harm and distrust with staff. Findings Included : Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] revealed, Section C- Cognitive patterns revealed a BIMS score of 13 which indicated Resident #1 was cognitively intact. Section GG- Functional Abilities and goals-Admission, revealed the resident required partial/moderate assistance with toileting hygiene. Section H-Bladder and Bowel revealed Resident #1 was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan dated 8/15/24 revealed Resident #1 was at risk for problems with elimination. The care plan goal reflected, the resident elimination status will be maintained or improved over the next 90 days. Interventions revealed, Assist to toilet as needed. Monitor for signs and symptoms of urinary tract infection. Additionally, the care plan reflected the resident's health condition prior to admission was healthy with no major physical or mental illnesses. Record review of Resident #1's urine analysis collected on 8/9/24 at 2:55PM, revealed a culture result of three or more organisms, probable contamination. Lab result was faxed to the facility on [DATE] at 8:03pm. Lab report revealed a written note New specimen obtained 8/11 signed by LVN B. Record review of Resident #1's urine analysis collected on 8/11/24 at 11:00 AM, revealed a culture result of staphylococcus epidermidis (gram-positive bacteria) and a sensitivity to oxacillin, tetracycline, and vancomycin (medication used to treat bacteria infections). Lab result was faxed to the facility on [DATE] at 12:07pm. Record review of Resident #1's EMR physician orders provided by the DON, dated 9/4/24 revealed, there were no orders located for the straight catheter procedure that occurred on 8/10/24. Record review Resident #1 hospital records dated 8/13/24 revealed a SANE exam was not conducted as there was no indication to conduct the exam. Furthermore, the exam revealed there was mild edema around the urethral meatus (inflammation, swelling and irritation) and that there was no evidence of trauma otherwise and no vaginal tenderness. Record review of Resident #1's EMR physician orders revealed, Order/Start date: 8/13/24. vancomycin 500 mg (antibiotic) intravenous solution 500 Milligram intravenously 2 times per day 7 Days. Dx: Urinary tract infection, site not specified. Order/Start Date Order Time 08/16/24 2 times per day. Vancomycin 500 mg intravenous solution 2 times per day 7 Days Dx: Urinary tract infection, site not specified. Record review revealed Resident #1 was also receiving vancomycin medication for a dx of Unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter. Record review of Resident #1 Trauma informed Observation, dated 8/12/24, revealed the assessment was completed with recommendations of resident wishes/goal, There's no reason to. Oriented to notify staff if when needs to talk and or would like therapy. Oh no I just want to get therapy, go home, see my old dog, she's 15 a [NAME], was electronically signed by [Name] Social Services Director 8/12/24 at 12:23 PM. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #1 on 9/4/24 at 12:34 PM, Resident #1 stated she believed she had a UTI around 8/9/24, and she had notified the staff. The staff proceeded to test her for the UTI. She stated she was provided a urine collection hat to urinate in for the urine sample. She stated staff told her that the sample could become contaminated due to the urine collection hats not being in a clean environment. She stated for years she had urinated in a little jar for UA tests. She stated Sunday morning, 8/11/24, at approximately 3am, staff had come into her room and did a catheter ,(small, flexible tube that is used to empty urine form the bladder) when she was unconscious. She stated she was asleep and was unconscious (sleeping), and staff had not told her anything until after she had woken up . She stated on 8/11/2024, the nurse, and the aide told her they came in to do a straight catheter to get a urine sample. She stated she had not known the prior urine specimen was contaminated until after they did the straight catheter. Resident #1 stated she was not told until after the procedure had been done. She stated she had never had a catheter in her life, and she had always refused them before. She stated she would have refused and never have consented to a catheter and that she would have preferred to provide a urine sample herself in a cup. She stated staff did not request another sample; they just took it from her. She stated she did not say anything to the nurses because she felt it was not the right time. Resident #1 stated she felt very violated, and she did not think the facility cared too much about her concerns. She stated the procedure was painful and she reported it on 8/12/24 to the ADM and she was sent to the ER for further evaluation. She stated the EDO physician explained she was swollen down there (vaginal area). Resident #1 stated she was in pain and the procedure was painful. Resident #1 stated she reported the incident to the police on 8/12/2024 when the facility called the local police to the facility. Resident #1 stated she did not understand why they could not wait to ask her for the sample during the day or in the morning instead of when she was unconscious. She stated they took a sample that would not have been sent out until late because it was on a Sunday and the lab place was not open until Monday. Resident #1 stated she felt she was taken advantage of, and that the procedure wasn't handled correctly, and that the catheter procedure was unnecessary. She also stated she felt violated, as if she had been raped and was very upset over the whole incident and had continued to be bothered and upset about it since the time it happened. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed there was no documentation by RN D, for Resident #1 reporting pain and discomfort with urination and requesting to be tested for a UTI on 8/9/24 or the days prior to. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed there was no communication between staff and physician for notification of Resident #1's change in condition. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed no documentation by LVN B or RN D's communication with a physician regarding a contaminated urine analysis. Record review of Resident #1's EMR physician orders revealed there was no order for a UA repeat and method of collection on 8/10/24 or 8/11/24. Record review of physician standing orders dated 6/19/2019 for MD revealed the following, Laboratory .54. Fasting Labs Upon Admission: BMP, CBC, U/A, lipid profile. Record review of Police call sheet dated 9/5/24 revealed, Police Sequence #P240807233 as of 9/5/24 11:18:55 . (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Created: 8/12/24 11:24:58 Entered: 8/12/24 11:57:47 Dispatch: 8/12/24 13:11:46 Enroute: 8/12/24 13:11:49 Onscene: 8/12/24 13:13:49 Closed: 8/12/24 14:07:35 11:54:58 Location: [Facility address], Name: [Redacted], Phone: [Redacted] 11:57:47 Comment: Victim [Redacted] Against a female nurse who went into her room at night/reported advised nurse was doing a procedure to extract urine and victim felt violated. 14:07:27 Comment: I spoke with [Redacted] who advised about 2 nights ago a nurse and a nurse aide woke her up and told her they needed a urine sample. [Redacted] advised she was groggy and still sleepy but advised later they came back in and advised her they put a catheter in to get a clean urine sample. [Redacted] advised she did not authorize a catheter to be put in and she felt violated, but advised she does not remember them even putting the catheter in. I spoke with the Administrator [Redated], who advised there is documentation that the doctor ordered the catheter for [Redacted] advised the nurses chart advised they put the catheter without any complaints from [Redacted], advised the nurse and aide who put the catheter were not at time but advised she would get in contact with them later to see what happened and why [Redacted] would be complaining now. I gave [Redacted] a sequence number for their records. There is clear documentation this was a medical procedure done at the request of the doctor. No crime occurred. 14:07:34 Clear. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 1:30 PM, the DON stated she was on leave when the incident occurred, but she believed the initial urine test was done based on the standing orders the EDO had for admission lab work which includes a urine test. She stated she knew the urine test was redone because the lab said it was contaminated. She stated they always do UA's every morning because the lab staff come in the mornings to draw labs and facility staff draw the UAs in-house. She stated Resident #1's admitting labs were dated on 8/13/24, she had UA lab results dated on 8/9/24. She stated she believed they were the results from a UA test done on 8/5/24, but she was not sure. She stated the rest of the standing order labs were done on 8/14/24. She stated she did not see an order for the UA in the EMR, only for the bloodwork, which were dated 8/14/24. She stated usually when a lab is contaminated, they would send a request to the FNP for a retest and a lot of times they prefer to redo the UA by straight catheter when they come back contaminated because it is cleaner. She stated she had not located an order for the straight catheter procedure. She stated she did not locate any documentation showing that the physician was notified of the straight catheter or that there was an order for the straight catheter. She stated she was not aware of any of those issues until the next day and she had not spoken to the resident. She stated she had not spoken to the nurse about the issue until now because she was not aware of it. She stated she expected for staff to document proper steps. She stated she was not aware if staff were trained how to document properly and the proper steps to take in those situations. She stated the original lab was faxed on 8/9/24 at 4:04 PM, which showed an abnormality, the facility received the contaminated lab results on 8/9/24 at 20:03 PM (8:03 PM). She stated the evening shift (2 PM-10 PM) would have been responsible to take care of it. She stated she had not seen any documentation that the evening shift took care of it. She stated it was not typical for a staff to do a procedure like that at 3:00 AM because residents were asleep, and it was not okay to take samples at that time because residents may not be clear on what was going on because they were in a dead sleep. She stated the UA recollection should have been done close to the time the fax was received between 8:00 PM-10:00 PM. She did not know why the culture was not done during the 2PM/10PM shift. She stated a potential negative outcome could be that the resident may not completely understand what was going on which could cause them to have felt something inappropriate went on. She stated the resident was not aware of what staff were doing which could make them think something else could be going on. She stated typically staff would have explained to the resident that the doctor ordered a straight catheter as well as explain why it is needed, which is how staff typically obtain consent from residents. She stated consent for straight cath procedures were obtained verbally from the resident and a lot of the time residents say no and the physician are then notified. She stated there should have been progress notes of communication with physician and verbal orders should have been documented in the EMR. She stated she never spoke to the resident because she had already been assessed and it was the end of the situation when she returned to work. DON stated the facility did in-service staff on abuse/neglect, customer services, resident rights, and for staff to explain the procedure before they start. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 4:03 PM, the ADM stated on 8/12/2024, she was told Resident #1 wanted to speak with her. The ADM stated Resident #1 told her she wanted to speak to her about an incident she was concerned about. The ADM stated Resident #1 told her she peed in a cup and was told the test came back contaminated. She stated Resident #1 told her that staff came in to repeat the UA and that it was at night and said, I felt I was raped. The ADM stated she explained that a straight catheter went into the urethra (hollow tube that lets urine, a waste product, leave the body) and asked Resident #1 if something went into her vagina, and she said she did not know. She stated Resident #1 said she would not have wanted a straight catheter. The ADM stated she told Resident #1 she would report it. She stated she called law enforcement and reported the incident to HHS. She stated they completed a skin assessment and there were no findings. She stated Resident #1 was sent to the hospital and asked for a rape kit, but the rape kit was not done due to the information Resident #1 provided to hospital staff about the incident during that examination. She stated Resident #1 stated she understood she was not raped and just did not want a catheter done and said she would have refused it. She stated she spoke to LVN B who said she was passed on report from RN D who told her the test was contaminated and that it needed to be repeated. She stated CNA A went in with LVN B because she wanted a second person for help in case the bed needed to be changed. The ADM stated both LVN B and CNA A said Resident #1 was awake and asked questions during the procedure, and that LVN B explained the procedure. She stated she was told Resident #1 tolerated the procedure without any issue and she appeared to be awake. She stated she was told Resident #1 said ouch, but that was all. She stated she was told Resident #1 had not expressed having an issue with the procedure. She stated RN D reached out to the FNP who gave the order to repeat the UA. She stated there should be an order to do a straight catheter. She stated consent was typically obtained by a resident verbally after the procedure was explained to them. She stated she thought [LVN B] did the procedure at 3:30 AM because she was trying to get it done before her shift ended. She stated it was typical to get a straight catheter sample to prevent getting another contaminated sample. She stated it could have delayed treatment if another contaminated sample was received. She stated staff called physicians or talked to them in person when they were in the building to obtain orders and that there should have been a progress note in the record when orders were received or documented in the 24-hour report. During an interview on 9/4/24 at 5:57 PM, the EDO stated he would have been fine with a resident providing their own urine sample when they were able to but would want the urine sample to be obtained by a straight catheter for residents who were unable to provide a urine sample on their own. He stated he felt nurses would know the best way to obtain the sample. He stated he believed the FNP was contacted about the UA orders for Resident #1. He stated he was aware Resident #1 reported feeling abused and violated by the straight catheter procedure and that she was sent to the emergency room for an examination. He stated after speaking with Resident #1, she realized she was not assaulted but insisted she did not like the way it was handled. He stated he was not sure if he saw Resident #1 afterwards. He stated he was not aware staff completed the straight catheter procedure on Resident #1 at 3:30 AM. He stated he hoped staff would not do a straight catheter procedure on a resident at that time of night. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 11:38 PM, CNA A stated LVN B asked her to help her get a urine sample from Resident #1, on 8/10/2024 after she arrived for the night shift but could not recall the exact time. She stated they got supplies together to go see Resident #1. She stated Resident #1 was asleep when they entered her room. She stated the dim lights were on in the room when they entered, and they turned the big light on during the procedure. She stated she asked Resident #1 to wake up and Resident #1 hummed like she did not want to wake up. CNA A stated she stayed in the room the whole time. She stated LVN B stepped out to get a collection bag. CNA A stated she had spoken to Resident #1 because she was still kind of knocked out (drowsy, did not stay awake, continued to fall back asleep). CNA A stated she asked Resident #1 if she needed water or anything else, and she said no. She stated then LVN B reentered the room. She stated Resident #1 asked what was going on and LVN B explained she needed a clean urine sample, Resident #1 replied that she already gave one, and then LVN B explained it was not a clean sample and they needed another one. CNA A stated Resident #1 said, Well I guess., then she undid the straps on the brief, and she wiped Resident #1 front to back. CNA A stated Resident #1's brief was dry when she undid the brief straps. She stated then LVN B wiped the area with a cotton swab that had alcohol/brown liquid on it. She stated she could not recall if LVN B told Resident #1 she was going to clean her with the cotton swab, but she did recall that LVN B told Resident #1 she was going to feel some pressure. She stated LVN B inserted the catheter and got the urine sample, removed the catheter, and completed her part. She stated Resident #1's eyes were open during the procedure, and she watched what was going on. She stated Resident #1 loudly said ouch when the catheter went in, and LVN B told her she had to insert a catheter to get a sample. CNA A stated LVN B did not explain where she was going to insert the catheter to get the sample. She stated after the procedure was over Resident #1 said, I guess this was a rude awakening. and she told Resident #1 she was sorry. She stated LVN B said, Sorry but it needed to be done. She stated there were no other words said between Resident #1 and LVN B after that. CNA A stated she stayed about five minutes to clean after LVN B stepped out. CNA A stated she put a clean brief on Resident #1 and picked up trash. She stated she changed the brief because it had dye and other stuff on it. She stated Resident #1 woke up after LVN B left. She stated Resident #1 was upset afterwards and said she felt like it was rude of them to go in at that time of night. She stated she checked on Resident #1 that shift a few more times and Resident #1 expressed it was rude each time she went into her room. CNA A stated she told LVN B that Resident #1 was upset and LVN B told her she would chart what all happened. CNA A stated she could not say if doing the procedure at 3:30 AM was not a good time. CNA A stated she saw Resident #1 right before she left her shift and Resident #1 told her she was not able to go back to sleep because she was mad and said it was rude of them to go in there and get the sample and she had not slept much because they woke her up. She stated Resident #1 did not express having pain afterwards. CNA A stated during the procedure, she held a box to make sure they didn't get urine on the bed sheet, and she did not assist with the straight catheter procedure. She stated Resident #1 always wore a brief at night but was not sure if she wore one during the day, but she knew Resident #1 went to the bathroom during the day. She stated Resident #1 had about four brief changes at night. She stated sometimes Resident #1 used the call light to request her brief be changed but sometimes her brief was wet during brief checks. CNA A stated the DON told her she needed to come in and speak with her and the ADM about the incident. CNA A stated she was suspended for a day because Resident #1 made allegations of being raped. CNA A stated no one expected have a catheter inserted in the middle of night. CNA A stated she also assisted LVN B during another straight catheter procedure that night with another female resident on hall 200 that was Spanish speaking. She stated she translated information between the resident and LVN B and translated the catheter process to that resident during the procedure. CNA A stated that procedure was before the procedure with Resident #1. She stated that resident was sitting on the side of her bed when they entered the room and said she needed to pee but could not go. She stated LVN B got the UA sample, and she cleaned the resident afterwards. CNA A provided information on recent in-service received on abuse/neglect, resident rights, customer service after the incident with Resident #1, and abuse/neglect, resident rights, customer service after the incident with Resident #2. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of an undated written statement provided by the facility of a statement given by CNA A revealed, [LVN B] asked me to go with her to help with the supplies while she was doing a straight catheter on [Resident #1]. [Resident #1] was asleep, and she woke her and said we have to get a sample from you. I made sure that she was awake. Resident #1 said she had already given a sample and asked why we needed another sample. [LVN B] explained it was contaminated and needed to redo it. [LVN B] prepped and completed the procedure, [LVN B] was explaining the whole time to [Resident #1] what was going on. [Resident #1] asked a few questions and was awake during the procedure. [Resident #1] said that it was painful at the time of the procedure. Throughout the night I continued to round on her, and she asked for water which I provided, she continued to thank me throughout the shift. (continued on next page)

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F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/5/24 at 12:25 AM, LVN B stated she arrived for her shift that night around 9:45 PM on 8/10/2024 and got report from RN D, who was the off-going nurse. She stated RN D told her Resident #1's urine test was contaminated, and they needed another specimen. LVN B stated she confirmed with RN D that Resident #1 was incontinent at night but could not recall if they discussed in report about doing a catheter. LVN B stated she remembered seeing the lab slip and that it said the specimen was contaminated, but she could not remember if the slip said to recollect a urine sample or if there was an order on the lab slip. LVN B stated she could not remember if RN D told her he spoke to anyone about the lab. LVN B stated she told CNA A they needed to collect a specimen and asked when she was doing care on Resident #1 so they could do the straight catheter procedure at the same time. She stated it was easier to have a CNA present to facilitate the process. She stated lab staff came every day any time after 5:00 AM to pick up specimens, so she was trying to get it done before then. LVN B stated Resident #1 was asleep when they entered her room, so they woke her up. She stated she explained to Resident #1 she was there to do the straight catheter procedure to get a urine sample and Resident #1 replied that she had already done one. She stated Resident #1 asked why she could not do it on the toilet, and she explained they needed a clean sample. LVN B stated she did not recall if Resident #1 had any other questions after that. LVN B stated she told Resident #1 that the UA was contaminated, and they needed another specimen. LVN B stated Resident #1 did not say anything to her after that, so she began the procedure. LVN B stated she explained to Resident #1 that she was going to put a tube in her. She stated Resident #1 said ouch, so she stopped and asked if she was okay, Resident #1 said yes, so she collected the specimen and completed the procedure, and then her brief was changed by CNA A. LVN B stated again she did not remember Resident #1 saying anything after she explained the procedure. She stated she felt she got informed consent from Resident #1 to complete the procedure because Resident #1 was cooperative during the procedure by spreading her legs when asked and Resident #1 allowed her to do the pre-cleaning without any issues. She stated Resident #1 also did not refuse the procedure when she told her about it, or she would not have done it. She stated she explained to Resident #1 every time she was going to do something and told her it would be uncomfortable. She stated she did the straight catheter procedure because Resident #1 was incontinent and symptomatic by complaining of not feeling well. LVN B stated Resident #1 had lab work done as well, and she believed they did the lab work when they did the first UA. She stated the facility did admission labs when residents first came in. LVN B stated she did not ask Resident #1 if she wanted to provide a urine sample by urine collection hat because she was incontinent at night and because the previous sample that was collected in that manner was contaminated and she wanted a clean specimen. LVN B stated part of the consent was verbal and part of it was demeanor. She stated Resident #1 responded to what she asked her to do and did not state she did not want to do it. She stated she did not know if residents had to say the exact words I agree, or I refuse. She stated, If they don't agree but they cooperate .I recall her saying okay and being aware of what we were doing. If she had said don't do that, then I wouldn't have done it. I believe she consented. She stated she felt Resident #1 was fully awake during the procedure because Resident #1 cooperated when she asked her to do things, such as scoot her bottom down and then spread her legs. LVN B stated she did not recall if there was any other conversation during the process. LVN B stated Resident #1 did not say anything afterwards and she left. LVN B stated later during the shift, she went to give Resident #1 some medication and Resident #1 asked LVN B why she did that to her and LVN B explained to Resident #1 that the previous test was contaminated, and they needed to get another urine sample and Resident #1 said okay. LVN B stated she did not call the FNP to get orders to perform the straight catheter procedure on Resident #1 because she was under the impression from report given to her by RN D that there was a physician's orders for the collection of the urine specimen from Resident #1, but she did not check to verify if there were orders. LVN B stated staff were supposed to have orders before doing an invasive procedure like that. She stated the order usually specified the way the urine specimen was collected, but she would clarify if that information was not written on the order. She stated she did not recall if RN D told her there was an order in the chart. She stated she was trained to verify orders before performing a procedure. LVN B stated, I don't guess I did that day. I do not remember seeing any physician orders. I don't recall if [RN D] told me he had notified the physician or if he had gotten an order. I just knew that I needed to collect a UA through the conversation with [RN D]. She stated no one told her that day that Resident #1 was upset. She stated she

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The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of an undated written statement provided by the facility of a statement given by LVN B revealed, When I came on shift there was a report on the fax machine that [Resident #1's] UA was contaminated. In verbal report from [RN D], I knew that she needed it collected again. During the day she is continent and at night she's fully incontinent and she doesn't communicate when she is wet. So, I knew that I needed to do a straight catheter due to the fact that the first UA was contaminated and that she is incontinent at night. [CNA A] and I went in together so that she could help me. I always bring a CNA with me so that she wouldn't have to change the whole bed afterwards if I didn't get the urine into the cup. We went in and woke her up to do the procedure, she was somewhat drowsy, but she was talking to us. I explained that we needed to get a UA she said we already got one earlier and she said it came back contaminated, so we needed to do a straight cath. LVN B showed her the

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 7 residents (Resident #1) reviewed for physician notification of changes. 1. The facility failed to follow their policy on change of condition by not immediately notifying the physician, and DON of Resident #1's UTI symptoms on 8/9/2024. 2. The facility failed to consult with Resident #1's physician and provide all necessary details, when Resident #1 complained of feeling burning and discomfort when urinating on 8/9/2024. This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death. The findings include: Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] Section C- Cognitive patterns revealed a BIMS score of 13 which indicates resident was cognitively intact. Section GG- Functional Abilities and goals- Admission, revealed resident required partial/moderate assistance with toileting hygiene. Section H- Bladder and Bowel revealed resident was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). Record review of Resident #1's care plan dated 8/15/2024 revealed resident was at risk for problems with elimination. Care plan goal stated, resident elimination status will be maintained or improved over the next 90 days. Interventions revealed, Assist to toilet as needed. Monitor for signs and symptoms of urinary tract infection. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal documentation by RN D, for Resident #1 reporting pain and discomfort with urination and requesting to be tested for a UTI on 8/9/24 or the days prior to. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal communication between staff and physician for notification of Resident #1's change in condition. During an interview with Resident #1 on 9/4/2024 at 12:34pm she stated she believed she had a UTI around 8/9/2024, and she had notified the staff (unsure what staff). The staff proceeded to test her for the UTI and obtained a urine sample on 8/9/2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 9/4/2024 at 1:30PM, she stated she believed the first UA was done on 8/9/2024 was part of the facility's standing orders for admission. The DON stated there should have been progress notes, and all orders should have been implemented and documented for the date and time received. During an interview with RN D on 9/4/2024 at 4:17pm, he stated he believed he collected the first UA sample on 8/9/24, that came back contaminated on 8/10/24. He stated Resident #1 had been complaining of burning when urinating and discomfort, so he had notified the FNP on 8/9/24. He stated at that same time he noticed the admitting labs had not been completed and the FNP stated okay, so he went ahead and did the UA. He stated he did not remember if he had put a note in about her having the urinary discomfort. He stated all communication should be documented in the progress notes, to protect themselves, especially if it was a new order. During an interview with FNP on 9/5/2024 at 12:47pm, she stated she had reviewed the UA for Resident #1. She stated she did not believe she had been called regarding Resident #1 having UTI symptoms on 8/9/24. She stated she was usually sent a text message, but she stated she did not have any text messages regarding that. Record Review of facility policy titled CHANGE OF CONDITION last revised February 13, 2023 revealed, Policy: The primary goal of identifying Acute Changes of Condition (ACOCs) is to enable staff to evaluate and manage a patient at the community and avoid transfer to a hospital or emergency room (ER). To achieve this goal, the community's staff and practitioners must recognize an ACOC and identify its nature, severity, and cause(s). The practitioner needs a detailed description of the patient's condition to determine whether a symptom is problematic or simply a normal or expected variant . Procedure: 1. Changes in condition of the patient are determined by current and past medical conditions, medical orders, patient safety factors and/or by assessments . .IMMEDIATE NOTIFICATION: Any symptom, sign or apparent discomfort that is: o Acute or sudden in onset, and: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o A Marked Change (i.e., more severe) in relation to usual symptoms and signs, or o Unrelieved by measures already prescribed . NON-IMMEDIATE NOTIFICATION: New or worsening symptoms that do not meet above criteria . 4. The nurse notifies the responsible physician or advanced practice nurse (APRN) utilizing appropriate channels and chain of command. 5. Document in the medical record the date, time, and name of each physician notified, actions taken and/or patient's response to treatment. Documentation should also include all nursing assessments and findings, nursing actions and notification of charge nurse/nurse supervisor. All entries in the HER will be automatically dated, timed and signed according to community policy.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interview and record review the facility failed to ensure residents were free from abuse for 2 of 7 residents (Resident #1 and Resident #2) reviewed for abuse in that: 1. The facility staff failed to protect Resident #1 from abuse when staff woke up the resident at approximately 3:30 AM on 8/11/24 and performed an invasive straight catheter procedure which caused Resident #1 physical pain and mental anguish, and Resident #1 reported she felt violated, traumatized, abused, and raped. 2. The facility failed to protect Resident #2 from verbal abuse from CNA C, when CNA C continued call Resident #2 names and belittle him and made a threat to do it again (call him names), at the nurse's station after being told to stop. An Immediate Jeopardy (IJ) situation was determined to have existed on 8/11/24. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance on 8/29/24, updated 9/4/24 prior to beginning of the survey. These failures could place residents at risk of physical harm, mental anguish, and emotional distress. Findings Included: 1. Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] revealed, Section C- Cognitive patterns revealed a BIMS score of 13 which indicated Resident #1 was cognitively intact. Section GG- Functional Abilities and goals- Admission, revealed the resident required partial/moderate assistance with toileting hygiene. Section H- Bladder and Bowel revealed Resident #1 was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). Record review of Resident #1's care plan dated 8/15/24 revealed Resident #1 was at risk for problems with elimination. The care plan goal reflected, the resident elimination status will be maintained or improved over the next 90 days. Interventions revealed, Assist to toilet as needed. Monitor for signs and symptoms of urinary tract infection. Additionally, the care plan reflected the resident's health condition prior to admission was healthy with no major physical or mental illnesses. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 12:34 PM, Resident #1 stated she believed she had a UTI around 8/9/24, and she had notified the staff. The staff proceeded to test her for the UTI. She stated she was provided a urine collection hat to urinate in for the urine sample. She stated staff told her that the sample could become contaminated due to the urine collection hats not being in a clean environment. She stated for years she had urinated in a little jar for UA tests. She stated Sunday morning, 8/11/24, at approximately 3am, staff had come into her room and did a catheter ,(small, flexible tube that is used to empty urine form the bladder) when she was unconscious. She stated she was asleep and was unconscious (sleeping), and staff had not told her anything until after she had woken up . She stated on 8/11/2024, the nurse, and the aide told her they came in to do a straight catheter to get a urine sample. She stated she had not known the prior urine specimen was contaminated until after they did the straight catheter. Resident #1 stated she was not told until after the procedure had been done. She stated she had never had a catheter in her life, and she had always refused them before. She stated she would have refused and never have consented to a catheter and that she would have preferred to provide a urine sample herself in a cup. She stated staff did not request another sample; they just took it from her. She stated she did not say anything to the nurses because she felt it was not the right time. Resident #1 stated she felt very violated, and she did not think the facility cared too much about her concerns. She stated the procedure was painful and she reported it on 8/12/24 to the ADM and she was sent to the ER for further evaluation. She stated the EDO physician explained she was swollen down there (vaginal area). Resident #1 stated she was in pain and the procedure was painful. Resident #1 stated she reported the incident to the police on 8/12/2024 when the facility called the local police to the facility. Resident #1 stated she did not understand why they could not wait to ask her for the sample during the day or in the morning instead of when she was unconscious. She stated they took a sample that would not have been sent out until late because it was on a Sunday and the lab place was not open until Monday. Resident #1 stated she felt she was taken advantage of, and that the procedure wasn't handled correctly, and that the catheter procedure was unnecessary. She also stated she felt violated, as if she had been raped and was very upset over the whole incident and had continued to be bothered and upset about it since the time it happened. Record review of a police call sheet dated 9/5/24 revealed, Police Sequence #P240807233 as of 9/5/24 11:18 AM: Created: 8/12/24 11:24:58 Entered: 8/12/24 11:57:47 Dispatch: 8/12/24 13:11:46 Enroute: 8/12/24 13:11:49 On scene: 8/12/24 13:13:49 Closed: 8/12/24 14:07:35 11:54:58 Location: [Facility address], Name: [Redacted], Phone: [Redacted] 11:57:47 Comment: Victim [Redacted] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Against a female nurse who went into her room at night/reported advised nurse was doing a procedure to extract urine and victim felt violated. 14:07:27 Comment: I spoke with [Redacted] who advised about 2 nights ago a nurse and a nurse aide woke her up and told her they needed a urine sample. [Redacted] advised she was groggy and still sleepy but advised later they came back in and advised her they put a catheter in to get a clean urine sample. [Redacted] advised she did not authorize a catheter to be put in and she felt violated, but advised she does not remember them even putting the catheter in. I spoke with the Administrator [Redated], who advised there is documentation that the doctor ordered the catheter for [Redacted] advised the nurses chart advised they put the catheter without any complaints from [Redacted], advised the nurse and aide who put the catheter were not at time but advised she would get in contact with them later to see what happened and why [Redacted] would be complaining now. I gave [Redacted] a sequence number for their records. There is clear documentation this was a medical procedure done at the request of the doctor. No crime occurred. 14:07:34 Clear. Record review of Resident #1's EMR physician's orders provided by the DON, dated 9/4/24 revealed, there were no orders located for the straight catheter procedure that occurred on 8/11/24. There were no orders for nighttime medications that would induce sleep. Record review of Resident #1 Trauma informed Observation, dated 8/12/24, revealed the assessment was completed with recommendations of resident wishes/goal, There's no reason to. Oriented to notify staff if or when needs to talk and or would like therapy. Oh no I just want to get therapy, go home, see my old dog, she's 15 a [NAME], was electronically signed by [Name] Social Services Director 8/12/24 at 12:23 PM. Record review Resident #1 hospital records dated 8/13/24 revealed a SANE exam was not conducted as there was no indication to conduct the exam. Furthermore, the exam revealed there was mild edema (inflammation, swelling and irritation) around the urethral meatus (opening that allows urine to exit the body) and that there was no evidence of trauma otherwise and no vaginal tenderness. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 1:30 PM, the DON stated she was on leave when the incident occurred with Resident #1 on 8/11/2024, but she believed the initial urine test was done based on the standing orders the EDO had for admission lab work which included a urine test. She stated she knew the urine test was redone because the lab said it was contaminated. She stated they always did UAs every morning because the lab staff came in the mornings to draw labs and facility staff drew the UAs in-house. She stated Resident #1's admitting labs were dated on 8/13/24, she had UA lab results dated on 8/9/24. She stated she believed they were the results from a UA test done on 8/5/24, but she was not sure. She stated the rest of the standing order labs were done on 8/14/24. She stated she did not see an order for the UA in the EMR, only for the bloodwork, which was dated 8/14/24. She stated usually when labs are contaminated, they would send a request to the FNP for a retest and a lot of times they prefer to redo the UA by straight catheter when they come back contaminated because it was cleaner. She stated she had not located an order for the straight catheter procedure. She stated she had not located any documentation showing that the physician was notified of the straight catheter or that there was an order for the straight catheter. The DON stated she was not aware of concerns Resident #1 voiced, until the next day 8/12/2024, and she had not spoken to the resident. The DON stated the ADM had spoken to Resident #1 and she was not at the facility because she had been sent to the ED. She stated she had not spoken to the nurse about the issue of the orders not received or documented, until now because she was not aware of it. She stated she expected for staff to document the proper steps. She stated she was not aware if staff were trained how to document properly and the proper steps to take in those situations (documented orders, care, consent). She stated the original lab was faxed to the facility on [DATE] at 4:04 PM, which showed an abnormality, the facility received the contaminated lab results on 8/9/24 at 20:03 PM (8:03 PM). She stated the evening shift (2 PM-10 PM) would have been responsible to take care of it. She stated she did not see any documentation that the evening shift took care of it. She stated it was not typical for a staff to do a procedure like that at 3:00 AM because residents were asleep, and it was not okay to take samples at that time because residents may not be clear on what was going on because they were in a dead sleep. She stated the UA recollection should have been done close to the time the fax was received between 8:00 PM-10:00 PM. She did not know why the culture was not done during the 2PM/10PM shift. She stated a potential negative outcome could be that the resident may not completely understand what was going on which could cause them to have felt something inappropriate went on. She stated the resident was not aware of what staff were doing which could make them think something else could be going on. She stated typically staff would have explained to the resident that the doctor ordered a straight catheter as well as explain why it is needed, which is how staff typically obtain consent from residents. She stated consent for straight cath procedures were obtained verbally from the resident and a lot of the time residents say no and the physician are then notified. She stated there should have been progress notes of communication with physician and verbal orders should also be documented in the EMR. She stated she never spoke to the resident because she had already been assessed and it was the end of the situation when she returned to work. She stated the facility started in-service with staff on abuse/neglect, resident rights, customer service, and explaining procedure before you start. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 4:03 PM, the ADM stated on 8/12/2024, she was told Resident #1 wanted to speak with her. The ADM stated when she went to speak with Resident #1, they both realized they knew each other from years ago when Resident #1's family member lived at a facility the ADM previously worked at. The ADM stated Resident #1 mentioned she was previously at another nursing home for rehabilitation services that the ADM was the ADM at, and they discussed how they did not have any contact with each other at that facility. The ADM stated Resident #1 told her she wanted to speak to her about an incident she was concerned about. The ADM stated Resident #1 told her she peed in a cup and was told the test came back contaminated. She stated Resident #1 told her that staff came in to repeat the UA and that it was at night and said, I felt I was raped. The ADM stated she explained that a straight catheter went into the urethra (hollow tube that lets urine, a waste product, leave the body) and asked Resident #1 if something went into her vagina, and she said she did not know. She stated Resident #1 said she would not have wanted a straight catheter. The ADM stated she told Resident #1 she would report it. She stated she called law enforcement and reported the incident to HHS. She stated they completed a skin assessment and there were no findings. She stated Resident #1 was sent to the hospital and asked for a rape kit, but the rape kit was not done due to the information Resident #1 provided to hospital staff about the incident during that examination. She stated Resident #1 stated she understood she was not raped and just did not want a catheter done and said she would have refused it. She stated she spoke to LVN B who said she was passed on report from RN D who told her the test was contaminated and that it needed to be repeated. She stated CNA A went in with LVN B because she wanted a second person for help in case the bed needed to be changed. The ADM stated both LVN B and CNA A said Resident #1 was awake and asked questions during the procedure, and that LVN B explained the procedure. She stated she was told Resident #1 tolerated the procedure without any issue and she appeared to be awake. She stated she was told Resident #1 said ouch, but that was all. She stated she was told Resident #1 had not expressed having an issue with the procedure. She stated RN D reached out to the FNP who gave the order to repeat the UA. She stated there should be an order to do a straight catheter. She stated consent was typically obtained by a resident verbally after the procedure was explained to them. She stated she thought [LVN B] did the procedure at 3:30 AM because she was trying to get it done before her shift ended. She stated it was typical to get a straight catheter sample to prevent getting another contaminated sample. She stated it could have delayed treatment if another contaminated sample was received. She stated staff called physicians or talked to them in person when they were in the building to obtain orders and that there should have been a progress note in the record when orders were received or documented in the 24-hour report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/4/24 at 4:17pm, RN D stated he received the lab report of the contaminated urine sample for Resident #1 the evening of near the end of his shift on 8/10/2024. He stated it had been a busy shift so at the end of the shift he told the oncoming nurse, LVN B, that he had not had time to report the lab and asked her to follow up on it. He stated he asked LVN B to notify the FNP. RN D stated he never spoke to the FNP on 8/10/24 and delegated it to LVN B. He stated he believed he collected the first UA sample via urine collection hat that came back contaminated. He stated Resident #1 complained of burning and discomfort during urination, so he had notified the FNP on 8/09/2024. He stated at that same time he noticed the admitting labs had not been completed and the FNP stated okay, so he went ahead and did the UA. RN D stated Resident #1 was very modest and did not like the male nurses to assist her. He stated she was adamant that she used the urine collection hat to provide the sample as that was how they usually collected her urine. RN D stated in his experience the urine collection hat often resulted in an anomaly. He stated he told Resident #1 if the sample came back contaminated, they may have to do a straight catheter. He stated Resident #1 said okay at that time, but he didn't think too much about it. He stated he did not remember if he had put a progress note in the EMR about her having the urinary discomfort. He stated the nurse who admitted the resident was responsible for initiating the admission labs. He stated all communication should have been documented in the progress notes to protect themselves, especially if it was a new order. He stated if he had reported the contaminated lab to the FNP, they probably would have said to do a straight catheter. He stated if he could not get ahold of the FNP, he would have waited until he received an order. He stated he would not have gone outside of his scope of practice. RN D provided information on recent in-service received on abuse/neglect, resident rights, customer service, and explaining procedure before you start, after the incident with Resident #1 and Resident #2. Record review of Resident #1's urine analysis collected on 8/9/24 at 2:55PM, revealed a culture result of three or more organisms, probable contamination. The lab result was faxed to the facility on [DATE] at 8:03pm. The lab report revealed a written note New specimen obtained 8/11, signed by LVN B. Record review of Resident #1's urine analysis collected on 8/11/24 at 11:00 AM, revealed a culture result of staphylococcus epidermidis (gram-positive bacteria) and a sensitivity to oxacillin, tetracycline, and vancomycin (medications used to treat bacterial infections). The lab result was faxed to the facility on [DATE] at 12:07pm. Record review of Resident #1's EMR physician orders revealed, Order/Start date: 8/13/24. vancomycin 500 mg (antibiotic) intravenous solution 500 Milligram intravenously 2 times per day 7 Days Dx: Urinary tract infection, site not specified. Order/Start Date Order Time 08/16/24 2 times per day. Vancomycin 500 mg (antibiotic) intravenous solution 2 times per day 7 Days Dx: Urinary tract infection, site not specified. Record review revealed Resident #1 was also receiving vancomycin medication for a dx of Unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity (space in the abdomen that contains the stomach, liver and intestines) subsequent encounter. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed, there was no documentation by RN D, for Resident #1 reporting pain and discomfort with urination and requesting to be tested for a UTI on 8/9/24 or the days prior to. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed, there was no documented communication between staff and physician for notification of Resident #1's change in condition. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/24 revealed no documentation by LVN B or RN D's communication with a physician regarding a contaminated urine analysis. Record review of Resident #1's EMR physician's orders revealed, there was no order for a UA repeat and method of collection on 8/10/24 or 8/11/24. Record review of the physician's standing orders dated 6/19/2019 for the MD revealed the following, Laboratory .54. Fasting Labs Upon Admission: BMP, CBC, U/A, lipid profile. During an interview on 9/4/24 at 5:57 PM, the EDO stated he would have been fine with a resident providing their own urine sample when they were able to but would want the urine sample to be obtained by a straight catheter for residents who were unable to provide a urine sample on their own. He stated he felt nurses would know the best way to obtain the sample. He stated he believed the FNP was contacted about the UA orders for Resident #1. He stated he was aware Resident #1 reported feeling abused and violated by the straight catheter procedure and that she was sent to the emergency room for an examination. He stated after speaking with Resident #1, she realized she was not assaulted but insisted she did not like the way it was handled. He stated he was not sure if he saw Resident #1 afterwards. He stated he was not aware staff completed the straight catheter procedure on Resident #1 at 3:30 AM. He stated he hoped staff would not do a straight catheter procedure on a resident at that time of night. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA A on 9/4/24 at 11:38 PM, CNA A stated LVN B asked her to help her get a urine sample from Resident #1, on 8/10/2024 after she arrived for the night shift but could not recall the exact time. She stated they got supplies together to go see Resident #1. She stated Resident #1 was asleep when they entered her room. She stated the dim lights were on in the room when they entered, and they turned the big light on during the procedure. She stated she asked Resident #1 to wake up and Resident #1 hummed like she did not want to wake up. CNA A stated she stayed in the room the whole time. She stated LVN B stepped out to get a collection bag. CNA A stated she had spoken to Resident #1 because she was still kind of knocked out (drowsy, did not stay awake, continued to fall back asleep). CNA A stated she asked Resident #1 if she needed water or anything else, and she said no. She stated then LVN B reentered the room. She stated Resident #1 asked what was going on and LVN B explained she needed a clean urine sample, Resident #1 replied that she already gave one, and then LVN B explained it was not a clean sample and they needed another one. CNA A stated Resident #1 said, Well I guess., then she undid the straps on the brief, and she wiped Resident #1 front to back. CNA A stated Resident #1's brief was dry when she undid the brief straps. She stated then LVN B wiped the area with a cotton swab that had alcohol/brown liquid on it. She stated she could not recall if LVN B told Resident #1 she was going to clean her with the cotton swab, but she did recall that LVN B told Resident #1 she was going to feel some pressure. She stated LVN B inserted the catheter and got the urine sample, removed the catheter, and completed her part. She stated Resident #1's eyes were open during the procedure, and she watched what was going on. She stated Resident #1 loudly said ouch when the catheter went in, and LVN B told her she had to insert a catheter to get a sample. CNA A stated LVN B did not explain where she was going to insert the catheter to get the sample. She stated after the procedure was over Resident #1 said, I guess this was a rude awakening. and she told Resident #1 she was sorry. She stated LVN B said, Sorry but it needed to be done. She stated there were no other words said between Resident #1 and LVN B after that. CNA A stated she stayed about five minutes to clean after LVN B stepped out. CNA A stated she put a clean brief on Resident #1 and picked up trash. She stated she changed the brief because it had dye and other stuff on it. She stated Resident #1 woke up after LVN B left. She stated Resident #1 was upset afterwards and said she felt like it was rude of them to go in at that time of night. She stated she checked on Resident #1 that shift a few more times and Resident #1 expressed it was rude each time she went into her room. CNA A stated she told LVN B that Resident #1 was upset and LVN B told her she would chart what all happened. CNA A stated she could not say if doing the procedure at 3:30 AM was not a good time. CNA A stated she saw Resident #1 right before she left her shift and Resident #1 told her she was not able to go back to sleep because she was mad and said it was rude of them to go in there and get the sample and she had not slept much because they woke her up. She stated Resident #1 did not express having pain afterwards. CNA A stated during the procedure, she held a box to make sure they didn't get urine on the bed sheet, and she did not assist with the straight catheter procedure. She stated Resident #1 always wore a brief at night but was not sure if she wore one during the day, but she knew Resident #1 went to the bathroom during the day. She stated Resident #1 had about four brief changes at night. She stated sometimes Resident #1 used the call light to request her brief be changed but sometimes her brief was wet during brief checks. CNA A stated the DON told her she needed to come in and speak with her and the ADM about the incident. CNA A stated she was suspended for a day because Resident #1 made allegations of being raped. CNA A stated no one expected have a catheter inserted in the middle of night. CNA A stated she also assisted LVN B during another straight catheter procedure that night with another female resident on hall 200 that was Spanish speaking. She stated she translated information between the resident and LVN B and translated the catheter process to that resident during the procedure. CNA A stated that procedure was before the procedure with Resident #1. She stated that resident was sitting on the side of her bed when they entered the room and said she needed to pee but could not go. She stated LVN B got the UA sample, and she cleaned the resident afterwards. CNA A provided information on recent in-service received on abuse/neglect, resident rights, customer service after the incident with Resident #1, and abuse/neglect, resident rights, customer service after the incident with Resident #2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of an undated written statement provided by the facility of a statement given by CNA A revealed, [LVN B] asked me to go with her to help with the supplies while she was doing a straight catheter on [Resident #1]. [Resident #1] was asleep, and she woke her and said we have to get a sample from you. I made sure that she was awake. Resident #1 said she had already given a sample and asked why we needed another sample. [LVN B] explained it was contaminated and needed to redo it. [LVN B] prepped and completed the procedure, [LVN B] was explaining the whole time to [Resident #1] what was going on. [Resident #1] asked a few questions and was awake during the procedure. [Resident #1] said that it was painful at the time of the procedure. Throughout the night I continued to round on her, and she asked for water which I provided, she continued to thank me throughout the shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/5/24 at 12:25 AM, LVN B stated she arrived for her shift that night around 9:45 PM on 8/10/2024 and got report from RN D, who was the off-going nurse. She stated RN D told her Resident #1's urine test was contaminated, and they needed another specimen. LVN B stated she confirmed with RN D that Resident #1 was incontinent at night but could not recall if they discussed in report about doing a catheter. LVN B stated she remembered seeing the lab slip and that it said the specimen was contaminated, but she could not remember if the slip said to recollect a urine sample or if there was an order on the lab slip. LVN B stated she could not remember if RN D told her he spoke to anyone about the lab. LVN B stated she told CNA A they needed to collect a specimen and asked when she was doing care on Resident #1 so they could do the straight catheter procedure at the same time. She stated it was easier to have a CNA present to facilitate the process. She stated lab staff came every day any time after 5:00 AM to pick up specimens, so she was trying to get it done before then. LVN B stated Resident #1 was asleep when they entered her room, so they woke her up. She stated she explained to Resident #1 she was there to do the straight catheter procedure to get a urine sample and Resident #1 replied that she had already done one. She stated Resident #1 asked why she could not do it on the toilet, and she explained they needed a clean sample. LVN B stated she did not recall if Resident #1 had any other questions after that. LVN B stated she told Resident #1 that the UA was contaminated, and they needed another specimen. LVN B stated Resident #1 did not say anything to her after that, so she began the procedure. LVN B stated she explained to Resident #1 that she was going to put a tube in her. She stated Resident #1 said ouch, so she stopped and asked if she was okay, Resident #1 said yes, so she collected the specimen and completed the procedure, and then her brief was changed by CNA A. LVN B stated again she did not remember Resident #1 saying anything after she explained the procedure. She stated she felt she got informed consent from Resident #1 to complete the procedure because Resident #1 was cooperative during the procedure by spreading her legs when asked and Resident #1 allowed her to do the pre-cleaning without any issues. She stated Resident #1 also did not refuse the procedure when she told her about it, or she would not have done it. She stated she explained to Resident #1 every time she was going to do something and told her it would be uncomfortable. She stated she did the straight catheter procedure because Resident #1 was incontinent and symptomatic by complaining of not feeling well. LVN B stated Resident #1 had lab work done as well, and she believed they did the lab work when they did the first UA. She stated the facility did admission labs when residents first came in. LVN B stated she did not ask Resident #1 if she wanted to provide a urine sample by urine collection hat because she was incontinent at night and because the previous sample that was collected in that manner was contaminated and she wanted a clean specimen. LVN B stated part of the consent was verbal and part of it was demeanor. She stated Resident #1 responded to what she asked her to do and did not state she did not want to do it. She stated she did not know if residents had to say the exact words I agree, or I refuse. She stated, If they don't agree but they cooperate .I recall her saying okay and being aware of what we were doing. If she had said don't do that, then I wouldn't have done it. I believe she consented. She stated she felt Resident #1 was fully awake during the procedure because Resident #1 cooperated when she asked her to do things, such as scoot her bottom down and then spread her legs. LVN B stated she did not recall if there was any other conversation during the process. LVN B stated Resident #1 did not say anything afterwards and she left. LVN B stated later during the shift, she went to give Resident #1 some medication and Resident #1 asked LVN B why she did that to her and LVN B explained to Resident #1 that the previous test was contaminated, and they needed to get another urine sample and Resident #1 said okay. LVN B stated she did not call the FNP to get orders to perform the straight catheter procedure on Resident #1 because she was under the impression from report given to her by RN D that there was a physician's orders for the collection of the urine specimen from Resident #1, but she did not check to verify if there were orders. LVN B stated staff were supposed to have orders before doing an invasive procedure like that. She stated the order usually specified the way the urine specimen was collected, but she would clarify if that information was not written on the order. She stated she did not recall if RN D told her there was an order in the chart. She stated she was trained to verify orders before performing a procedure. LVN B stated, I don't guess I did that day. I do not remember seeing any physician orders. I don't recall if [RN D] told me he had notified the physician or if he had gotten an order. I just knew that I needed to collect a UA through the conversation with [RN D]. She stated no one told her that day that Resident #1 was upset. She stated she

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview, and record review the facility failed to ensure a resident, who was continent of bowel and bladder, received appropriate treatment for a urinary tract infection, for 1 of 7 residents (Resident #1) reviewed for urinary straight catheters. 1. The facility failed to ensure Resident #1 had a physician order prior to performing a straight catheter procedure. 2. The facility failed to follow their policy on urine specimen collection by not determining the appropriate measurement method for urine collection. 3. The facility failed to follow their policy on physician orders by not receiving and transcribing physician orders for a UA recollection for Resident #1. 4. The facility failed to follow the physician order for Resident #1 by performing an invasive straight catheter procedure when the physician order did not specify what method of UA recollection was needed. These failures could place the residents at risk of unnecessary straight catheter procedures and risk for urinary tract infections. Findings Included: Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] Section C- Cognitive patterns revealed a BIMS score of 13 which indicates resident was cognitively intact. Section GG- Functional Abilities and goals- Admission, revealed resident required partial/moderate assistance with toileting hygiene. Section H- Bladder and Bowel revealed resident was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). Record review of Resident #1's care plan dated 8/15/2024 revealed resident was at risk for problems with elimination. Care plan goal stated, resident elimination status will be maintained or improved over the next 90 days. Interventions revealed, Assist to toilet as needed. Monitor for signs and symptoms of urinary tract infection. Record review of Resident #1's urine analysis collected on 8/9/2024 at 2:55PM, revealed a culture result of three or more organisms, probable contamination. Lab result was faxed to the facility on [DATE] at 8:03pm. Lab report revealed a written note New specimen obtained 8/11 signed by LVN B. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's urine analysis collected on 8/11/2024 at 11:00 AM, revealed a culture result of staphylococcus epidermidis (bacteria that can cause an infection) and a sensitivity to the antibiotics oxacillin, tetracycline, and vancomycin. Lab result was faxed to the facility on [DATE] at 12:07pm. Record review of Resident #1's EMR physician orders revealed, Order/Start date: 8/13/2024. vancomycin 500 mg intravenous solution 500 Milligram intravenously 2 times per day 7 Days Dx: Urinary tract infection, site not specified. Order/Start Date Order Time 08/16/2024 2 times per day. Vancomycin 500 mg intravenous solution 2 times per day 7 Days Dx: Urinary tract infection, site not specified. During an interview with Resident #1 on 9/4/2024 at 12:34pm she stated she believed she had a UTI around 8/9/2024, and she had notified the staff. The staff proceeded to test her for the UTI and obtained a urine sample on 8/9/2024. She stated they had originally given her a urine collection hat to urinate in for a urine sample. She stated staff told her that the sample could become contaminated due to the hats not being in a clean environment. She stated for years she had urinated in a little jar for UA's. She stated one Sunday morning, 8/11/2024, at approximately 3am, staff had come into her room and did a catheter when she was unconscious (sleeping). She stated she was asleep, and staff had not told her anything until after she woke up. She stated the nurse, and the aide told her they came in to do a straight catheter for a urine sample. She stated she did not know the prior urine specimen was contaminated until after they did the straight cath. Resident #1 stated they had told her after they did the procedure not before and if she had known prior to the procedure about the catheter, she would have refused. She stated staff did not request another sample they just took it from her. She stated she remembers the procedure was painful and she reported it on 8/12/24 to the ADM and was sent to the ED for further evaluation. She stated the ED physician explained she was swollen down there (vaginal area). Resident #1 stated she was in pain and the procedure was painful. Resident #1 stated she reported the incident to the police. Resident #1 stated she wanted to know why they did not ask for the sample in the day or in the morning. She stated they were taking a sample that would not be sent out until late. Resident #1 stated she felt that she was taken advantage of, violated, and almost as if she had been raped. She stated she did not feel the procedure was handled correctly. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal documentation by RN D, for Resident #1 reporting pain and discomfort with urination and requesting to be tested for a UTI on 8/9/24 or the days prior to. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal LVN B or RN D's communication with physician regarding a contaminated urine analysis. Record review did not reveal documentation of a phone order obtain for recollection by straight cath from the physician or by the nurse who obtained the order. Record review of Resident #1's EMR physician orders did not reveal an order for a UA repeat and method of collection on 8/10/2024 or 8/11/2024. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of written physician's telephone orders for Resident #1 revealed, Date ordered: 8/5/2024 1545 (3:45pm) clarification order: Admission UA w/ C/S if indicated Signed by DON on 9/4/2024 at 1500 (3:00pm) and by FNP 9/4/2024. Record review of written physician's telephone orders for Resident #1 revealed, Date ordered 8/10/2024 at 9:40pm Clarification order: Recollect UA due to contamination. Signed by DON on 9/4/2024 at 1500 (3:00pm) and by FNP 9/4/2024. Written order did not reveal the method of UA collection. Record review of facility timesheets revealed, RN D on 8/10/2024 had a start time of 5:54pm and an end time of 10:53pm. Record review of facility timesheet revealed, LVN B on 8/10/2024 had a start time of 9:51pm and an end time of 6:14 AM on 8/11/2024. During an interview with the DON on 9/4/2024 at 1:30PM, she stated the urine analysis had been repeated because the lab had stated the other sample was contaminated. She stated she believed the first UA was done as part of the facility's standing orders for admission. She stated they always obtain the UA and any stat labs. The DON stated the admitting labs were done on 8/13/2024 and a UA that was performed on 8/9/2024. The DON stated there was not UA or admission labs (CBC, CMP, and lipid panel) done on 8/5/2024 and she was not sure why they were not done on admission. She stated she was unable to see an order for the repeat UA, only the lab work and those were dated 8/14/2024. She stated she could not locate an order for the straight cath or UA on 8/10/24 or 8/11/2024. The DON stated the UA lab results were sent to the NP and depending on the reasoning for the UA, they would give an order for the second one. She stated typically if a UA comes back contaminated the physician would order a straight cath. She stated on 8/11/2024 LVN B had documented Lab stated prior urine specimen was contaminated. Urine specimen obtained via straight cath for lab. Resident tolerated procedure without difficulty. The DON stated she did not see any documentation from LVN B communicating with the physician. The DON stated she was not seeing an order or that LVN B received an order for the UA repeat with a straight cath. The DON stated she never spoke to Resident #1 but had been made aware of the resident feeling uncomfortable during the procedure. She stated at that time Resident #1 was already at the hospital. She stated she was not aware there was a problem until now. She stated that was not what she expects of her nurses, and she did not know if the night staff needed to be educated on the proper procedure. She stated night staff did not typically do those kinds of things and that those UA collections were usually done on the day shift. The DON stated the 2-10pm shift should have called the physician and gotten new orders. She stated she did not see any documentation on notifying the physician. The DON stated it was not typical for UA straight caths to be performed at 3am. She stated the residents were asleep and doing a procedure while they were asleep was not okay and they were not clear on what was going on. She stated the procedure should have been done when the order was given or obtained. She stated she did not know why LVN B would have done it at 3am. She stated a negative outcome could be the residents not understanding what was going on and them feeling something that was not appropriate. She stated the residents may not be coherent of what was going on and it could potentially make them feel like something else was going on. She stated consent for straight cath procedures were obtained verbally from the resident and a lot of the time residents say no and the physician was then notified. The DON stated there should have been progress notes, and all orders should have been implemented and documented for the date and time received. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM on 9/4/2024 at 4:03pm, she stated Resident #1 had spoken to her on 8/12/24 about a procedure that had been performed on 8/11/2024. She stated Resident #1 had expressed feeling as if she had been raped. The ADM stated she explained to Resident #1 that the catheter went into her urethra (hollow tube that lets urine, a waste product, leave the body). The ADM stated Resident #1 had expressed not wanting a straight catheter done. She stated she told Resident #1 she would report the incident to the state, and a skin assessment was performed. She stated the skin assessment did not reveal anything that looked like that to us so we sent to the hospital and asked for a rape kit. The ADM stated the hospital did not perform a rape kit as Resident #1 had no vaginal contact done. She stated she spoke to LVN B, and she had stated it had been passed down in report that the previous urine sample had been contaminated and they needed a recollection. She stated RN D told LVN B that there was a new order for a UA to be repeated. ADM stated CNA A and LVN B both went into Resident #1's room to perform the straight catheter. ADM stated both staff members stated that Resident #1 was awake and that LVN B had explained what she was doing to Resident #1. The ADM stated CNA A told her Resident #1 did say ouch for a second and then LVN B was done with the procedure. ADM stated CNA A did not see Resident #1 have an issue with the procedure. The ADM stated RN D had reached out to FNP for the UA order after he received the lab report stating the prior UA had been contaminated. The ADM stated consent for procedures such as straight catheters require d a physician order and the consent was usually obtained verbally from the residents. The ADM stated LVN B was just trying to get the UA recollection done at 3am. She stated Resident #1 was pretty grateful that they had gotten the UTI and been able to treat it. The ADM stated it was very clear from the two staff that the resident was alert prior to performing the procedure. She stated staff communicate with physicians by phone and sometimes they come in person to give orders. She stated she would have to find out why the standing orders were delayed and not done on admission. She stated ideally staff was to put in the orders on the progress notes and pass it on in report. During an interview with RN D on 9/4/2024 at 4:17pm, he stated he had received the lab report of the contaminated urine sample. He stated it had been a busy shift so at the end of the shift he told the oncoming nurse, LVN B, that he had not had time to report the lab and if she would be able to follow up on it. He stated he asked her to notify the FNP. RN D stated he never spoke to the FNP on 8/10/24 and delegated it to LVN B. He stated he believed he collected the first UA sample that came back contaminated. He stated Resident #1 had been complaining of burning when urinating and discomfort, so he had notified the FNP . He stated at that same time he noticed the admitting labs had not been completed and the FNP stated okay, so he went ahead and did the UA. RN D stated Resident #1 was very modest and did not like the male nurses to assist her. He stated she was adamant that she uses the urine collection hat as that was how they usually collected her urine sample. RN D stated in his experience the urine collection hat often results in an anomaly. He stated he told Resident #1 if the sample came back contaminated, they may have to do a straight cath. He stated Resident #1 said okay and agreed at that time, but he did not think too much about it. He stated he did not remember if he had put a note in about her having the urinary discomfort. He stated the nurse who admits the residents was responsible for initiating the admission labs. He stated all communication should be documented in the progress notes, to protect themselves, especially if it was a new order. He stated if he had reported the contaminated lab to the FNP, they probably would have said to do a straight cath . He stated if he could not get a hold of the FNP, he would have waited until he received an order. He stated he would not go past his scope of practice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 5:57 PM, the EDO stated he would have been fine with a resident providing their own urine sample when they were able to but would want the urine sample to be obtained by a straight catheter for residents who were unable to provide a urine sample on their own. He stated he felt nurses would know the best way to obtain the sample. He stated he believed the FNP was contacted about the UA orders for Resident #1. He stated he was aware Resident #1 reported feeling abused and violated by the straight catheter procedure and that she was sent to the emergency room for an examination. He stated after speaking with Resident #1, she realized she was not assaulted but insisted she did not like the way it was handled. He stated he was not sure if he saw Resident #1 afterwards. He stated he was not aware staff completed the straight catheter procedure on Resident #1 at 3:30 AM. He stated he hoped staff would not do a straight catheter procedure on a resident at that time of night. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA A on 9/4/2024 at 11:38 PM, she stated she usually worked the 10pm- 6am shift. She stated she remembered Resident #1 and was in the room the day they did the procedure for the urine sample. She stated LVN B had asked her to help her with the residents she needed to get a UA for. She stated LVN B had a couple residents she needed to do that night. She stated they went into Resident #1's room and Resident #1 was asleep when they had entered. She stated LVN B stepped out to grab a bag and CNA A attempted to wake Resident #1. She stated Resident #1 was still in a sleep state, she was coming out of her sleep, but she was still knocked out. CNA A stated she called Resident #1's name and was gently telling her to wake up. She stated Resident #1 did not want to wake up, and she was in a humming state, like moaning. CNA A stated when LVN B came back Resident #1 asked her what was going on and LVN B told her she needed a clean urine sample. She stated Resident #1 told LVN B she had already given one and LVN B told her the sample she gave was dirty and they needed to collect another one. She stated Resident #1 said I guess. CNA A stated she unfastened the brief and cleaned Resident #1 with wipes and then LVN B cleaned Resident #1 with the large brown cotton swabs. She stated LVN B proceeded to insert the catheter and got her sample. She stated Resident #1 stated, This was a rude awakening. CNA A stated she told Resident #1 she was sorry and LVN B told her she was sorry, but it was something that needed to be done. CNA A stated she put a clean brief on Resident #1 and took out the trash. CNA A stated she did not think there were any more words between LVN B and Resident #1. CNA A stated she did not believe LVN B explained the procedure just that she needed another sample. CNA A stated LVN B did explain she needed a clean sample and showed Resident #1 the catheter and explained that was the only way we could get a clean sample. She stated LVN B explained she was going to insert the catheter but did not explain where. CNA A stated she did not recall LVN B explaining the cleaning to Resident #1. She stated LVN B let Resident #1 know she would feel some pressure. CNA A stated when LVN B began to insert the catheter Resident #1 said ow and it was pretty loud. CNA A stated after LVN B was done, CNA A began cleaning simply because the brief had the red dye, and she applied a new clean brief on Resident #1. CNA A stated Resident #1 was awake when LVN B left. CNA A stated during the procedure she looked at Resident #1 and her eyes were open, and she was awake watching what was going on and Resident #1 had asked What's going on, what's happening. CNA A stated Resident #1 was upset about the procedure, and she felt that it was rude of them to go in there and get a sample. She stated Resident #1 told her it was a rude awakening. CNA A stated she did not remember what time they did the procedure but on the next brief change Resident #1 was still upset about it saying it was rude. CNA A stated she did report the resident being upset to LVN B and she was told by LVN B she would chart it. CNA A stated she did not know if I guess was enough of a consent. CNA A stated before the end of her shift, Resident #1 told her she was upset, and she did not go back to sleep, and she did not sleep well. CNA A stated she had been called by the DON to speak to the ADM. She stated they asked her what had happened that night and CNA A told them what had happened. CNA A stated I was suspended I guess for a day, and I wasn't sure why because I don't know. They said that there was an allegation of rape with Resident #1, and I was like ok. To me I couldn't wrap that around my head. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 9/5/2024 at 12:25 AM, she stated she arrived at the facility on 8/10/24 at approximately 9:45pm. She stated she got to Hall 3 at around 10pm. LVN B stated she received report from who she believes was RN D. She stated According to my recollection he told me the urine had come back contaminated and we needed to collect another specimen. I remember telling him that she was incontinent at night, and he said yea that's and I believe .it's been a while we probably talked about cathing (a procedure that involves inserting a tube into the bladder to drain urine or inject liquids). You know how it is, you do things and then get to the next. I believe during the day she was continent but at night she is incontinent. I'm not positive if we talked about cathing. I remember seeing the lab slip saying that it was contaminated I don't remember seeing anything written on it. I don't remember seeing an order for recollection. I don't remember if he mentioned if he did or did not speak to anyone about the lab. I would think probably but I can't guarantee that. She stated she had told CNA A that they would have to collect a urine specimen and to be notified of the next time she was going to provide care and they could do it all together. LVN B stated lab normally comes at 5 o'clock but she did not remember what time they went into Resident #1's room. She stated she explained to Resident #1 that they were in there to do a straight cath for a specimen. She stated Resident #1 told her she had already given one and LVN B told her that urine had been contaminated and they needed another specimen. LVN B stated she did not remember Resident #1 having any other questions. She stated she told her she would be putting a little tube in her to get the specimen. LVN B stated CNA A was in the room to help her and Resident #1 because it makes the process easier. LVN B stated Resident #1 said ouch but that it was not uncommon. She stated she stopped for a second and asked if she was okay and Resident #1 said yeah. LVN B stated she proceeded with the procedure and that was the end of that. She stated Resident #1 did not really say anything and she was cooperative during the procedure. She stated Resident #1 did not say anything after she explained the procedure to her. LVN B stated Resident #1 was cooperative during the procedure and had allowed her to do the precleaning and spread her legs for her to do the insertion. LVN B stated she walked Resident #1 through the procedure. LVN B stated again she did not remember Resident #1 saying anything after she explained the procedure. LVN B stated she was prompted to do the UA straight cath because Resident #1 was incontinent, and she already had one contaminated attempt. LVN B stated Resident #1 had been symptomatic, and she had complained of not feeling well. LVN B stated Resident #1 had lab work done as well, and she believed they did the lab work when they did the first UA. She stated the facility did admission labs when residents first come in. LVN B stated she never gave Resident #1 the option to use a hat for UA collection and she never asked Resident #1. LVN B stated she did not ask Resident #1 if she wanted to use a hat to give a sample because she was incontinent at night. She stated part of the consent was verbal and part of it was demeanor. She stated Resident #1 was responding to what she was asking her to do and did not state I don't want to do this. She stated she did not know if residents had to say the exact words I agree, or I refuse. She stated If they don't agree but they cooperate .I recall her saying okay and being aware of what we were doing. If she had said don't do that, I wouldn't have done it. I believe she consented. LVN B stated she believes Resident #1 was fully awake during the procedure and she was cooperative by following prompts and spreading her legs or scooting her bottom as needed. LVN B stated later that night when she went to give Resident #1 her medications, she stated Resident #1 asked her why she had to do that to her, and she explained to Resident #1 that the specimen had been contaminated and they needed another sample. She stated Resident #1 said okay. LVN B stated she was under the impression there were UA recollection orders from the report given by RN D. She stated she remembers discussing the sample contamination and getting another specimen with RN D. She stated they were supposed to receive orders before performing a procedure like that. LVN B stated a typical order would state collect UA via straight cath and if it did not say straight cath she would clarify with the physician. LVN B stated she was trained to verify orders before performing a procedure. LVN B stated I don't guess I did that day. I do not remember seeing any physician orders, I don't recall if RN D told me he had notified the physician or if he had gotten an order. I just knew that I needed to collect a UA through the conversation with RN D. LVN B stated the facility liked for night shift to collect the urine specimens unless it was a stat situation but for the most part, routine admission labs were done by the night shift. She stated she normally lets the CNAs know if a UA had to be collected so she can do it during their next peri care or if they were requesting pain medication, or something they would be awake for. She stated they liked for us to have everything done

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM and DON on 9/5/2024 at 1:35 AM, ADM stated the UA should have been done on 8/5/2024 and nobody had followed that order. She stated the UA order should have been given on 8/5/2024. The DON stated the FNP could not remember who called her, but FNP remembers receiving results of the orders and that was why she obtained that physician written orders for the UA recollection and the UA admission order. During an interview with FNP on 9/5/2024 at 12:47pm, she stated she expected the standing orders for admission labs to be done at the time of resident's admission to the facility. She stated she was not aware the admission labs had not been done. She stated she had reviewed the UA for Resident #1, but she did not know the labs had not been done on admission. She stated she did not believe she had been called regarding Resident #1 having UTI symptoms on 8/9/24. She stated she was usually sent a text message, but she stated she did not have any text messages regarding that. She stated if lab results come back abnormal during the night, staff would call her if she was on call but if another colleague was on call they would wait until the morning for orders unless they were critical. She stated if a contaminated UA comes back during the night, her colleagues would have requested the staff wait until morning for FNP to give an order because it was not emergent at 3am. She stated she believes someone called her on 8/10/2024 but she did not remember who. She stated she did specify in her orders if a UA should be done by clean catch or straight cath. She stated for Resident #1 she would have requested a clean catch. She stated she was not notified about Resident #1 feeling violated after the straight cath. She stated she was not aware of a straight cath done at 3am for Resident #1 and even if there was an order for it to be done it could have waited until the morning. She stated she did come in on 9/4/2024 to sign the UA orders. During an interview on 9/6/24 at 11:41 AM, Resident #1 stated she did not want other residents to go through what she did. She stated the more she thought about it, the more she felt violated and traumatized. She stated that she had continued to think about it since the incident happened. Record Review of facility policy titled URINE SPECIMEN COLLECTION, last revised February 12, 2020, revealed, Standard of Practice: Staff will use appropriate methods to a urine sample for laboratory and diagnostic purposes in accordance with standard practice guidelines Procedure: . o Determine the appropriate measurement method for the patient. Measurement methods may include, but are not limited to: o Clean voided/midstream collection o Sterile Urinary Catheter collection . .Obtain the urine specimen. o If the resident is able to obtain specimen, provide supplies, privacy, and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance as appropriate o In other cases, provide assistance as needed Record Review of facility policy titled INSERTION OF A STRAIGHT OR INDWELLING URINARY CATHETER last reviewed February 17, 2023, revealed, Policy: Staff will insert a straight or indwelling urinary catheter in accordance with standard practice. guidelines. Procedure: . .2) Determine the appropriate order for type and size of catheter. .4) Explain procedure and answer resident's questions regarding urine collection. Record Review of facility policy titled PHYSICIAN ORDERS (Admission) last revised January 12, 2020, revealed, Standard of Practice: The licensed nurse will obtain and transcribe orders according to Practice Guidelines Procedures: 1. The licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer orders is not credentialed by the health care center, the designated attending physician is contacted to confirm the transfer order and request any additional orders.

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F 0771 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure laboratory services, blood blanks and transfusion services provided on-site meet requirements for certified laboratories. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of its residents for 1 of 7 residents (Resident #1) reviewed for laboratory services in that: 1. The facility failed to follow physician standing orders for lab blood analysis, on facility admission of Resident #1. These failures could place residents at risk of not having laboratory services completed and cause delay in their care. Findings include: Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] Section C- Cognitive patterns revealed a BIMS score of 13 which indicates resident was cognitively intact. Section GG- Functional Abilities and goals- Admission, revealed resident required partial/moderate assistance with toileting hygiene. Section H- Bladder and Bowel revealed resident was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). Record review of physician standing orders dated 6/19/2019 by MD revealed the following, Laboratory .54. Fasting Labs Upon Admission: BMP, CBC, U/A, lipid profile. Record review of Resident #1's lab results document revealed labs were obtained on 8/14/2024 at 1700 (5:00pm). Lab results were received by the facility on 8/14/2024 at 22:05 (10:05pm). During an interview with the DON on 9/4/2024 at 1:30PM, she stated there was not UA or admission labs (CBC, BMP , and lipid panel) done on 8/5/2024 for Resident #1. She stated she was not sure why they were not done on admission. She stated she saw the lab work and those were dated 8/14/2024. During an interview with the ADM on 9/4/2024 at 4:03pm, she stated she would have to find out why the standing lab orders were delayed and not done on admission. She stated ideally staff was to put in the orders on the progress notes and pass it on in report. (continued on next page)

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F 0771 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN D on 9/4/2024 at 4:17pm, he stated Resident #1 had been complaining of burning when urinating and discomfort, so he had notified the FNP on 8/9/24. He stated at that same time he noticed the admitting labs had not been completed and the FNP stated okay to do them, so he went ahead and did the UA. He stated the nurse who admits the residents were responsible for initiating the admission labs. He stated all communication should be documented in the progress notes, to protect themselves, especially if it was a new order. During an interview with LVN B on 9/5/2024 at 12:25 AM, she stated admission labs should be done the next day unless it was the weekend then they get pushed back for the following Monday. She stated they had a lab that would do those lab draws unless they were stat orders then the facility staff would draw the lab work. During an interview with FNP on 9/5/2024 at 12:47pm, she stated she expected the standing orders for admission labs to be done at the time of resident's admission to the facility. She stated she was not aware the admission labs had not been done. She stated she had reviewed the UA for Resident #1, but she did not know the labs had not been done on admission. Record Review of facility policy titled PHYSICIAN ORDERS (Admission) last revised January 12, 2020, revealed, Standard of Practice: The licensed nurse will obtain and transcribe orders according to Practice Guidelines Procedures: 1. The licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer orders is not credentialed by the health care center, the designated attending physician is. contacted to confirm the transfer order and request any additional orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 7 residents (Residents #1) reviewed for accuracy of medical records in that 1. The facility failed to document communication between RN D and Resident #1 when Resident #1 reported feeling as if she had a UTI on 8/9/2024. 2. The facility failed to document Resident #1's change in condition when she reported to staff, she felt she had a UTI on 8/9/2024. 3. The facility failed to document communication between RN D and FNP when Resident #1 reported feeling as if she had a UTI and obtaining an order for the UA on 8/9/2024. 4. The facility failed to document communication between staff and FNP when a contaminated UA sample was reported to the facility on [DATE] at 8:30pm for Resident #1. 5. The facility failed to document when the FNP ordered a UA recollection order for Resident #1, and what time and staff member obtained that order. 6. The facility failed to document Resident #1's report of feeling upset and violated after a straight cath was performed on 8/11/2024 at approximately 3:30 AM. These failures could affect residents whose records are maintained by the facility and could place the residents at risk for errors in care and treatment. The findings included: Resident #1 Record review of Resident #1's undated face sheet revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had a medical history of acute kidney failure (kidneys no longer work on their own), muscle weakness (lack of strength), and muscle wasting (thinning of muscle). Record review of Resident #1's MDS dated [DATE] Section C- Cognitive patterns revealed a BIMS score of 13 which indicates resident was cognitively intact. Section GG- Functional Abilities and goals- Admission, revealed resident required partial/moderate assistance with toileting hygiene. Section H- Bladder and Bowel revealed resident was always continent of urinary and bowel and Resident #1 did not have any appliances (indwelling catheters, intermittent catheterization). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 8/15/2024 revealed resident was at risk for problems with elimination. Care plan goal stated, resident elimination status will be maintained or improved over the next 90 days. Interventions revealed, Assist to toilet as needed. Monitor for signs and symptoms of urinary tract infection. During an interview with Resident #1 on 9/4/2024 at 12:34pm she stated she believed she had a UTI around 8/9/2024, and she had notified the staff . The staff proceeded to test her for the UTI and obtained a urine sample on 8/9/2024. She stated they had originally given her a urine collection hat to urinate in for a urine sample. She stated staff told her that the sample could become contaminated due to the hats not being in a clean environment. She stated for years she had urinated in a little jar for UA's. She stated one Sunday morning, 8/11/2024, at approximately 3am, staff had come into her room and did a catheter when she was unconscious (sleeping). She stated she was asleep, and staff had not told her anything until after she woke up. She stated the nurse, and the aide told her they came in to do a straight catheter for a urine sample. She stated she did not know the prior urine specimen was contaminated until after they did the straight cath. Resident #1 stated they had told her after they did the procedure not before and if she had known prior to the procedure about the catheter, she would have refused. She stated staff did not request another sample they just took it from her. She stated she remembers the procedure was painful and she reported it on 8/12/24 to the ADM and was sent to the ED for further evaluation. She stated the ED physician explained she was swollen down there (vaginal area). Resident #1 stated she was in pain and the procedure was painful. Resident #1 stated she reported the incident to the police. Resident #1 stated she wanted to know why they did not ask for the sample in the day or in the morning. She stated they were taking a sample that would not be sent out until late. Resident #1 stated she felt that she was taken advantage of, violated, and almost as if she had been raped. She stated she did not feel the procedure was handled correctly. (continued on next page)

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	676105	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 9/4/2024 at 1:30PM, she stated the urine analysis had been repeated because the lab had stated the other sample was contaminated. She stated she believed the first UA was done as part of the facility's standing orders for admission. She stated she was unable to see an order for the repeat UA. She stated she could not locate an order for the straight cath or UA on 8/10/24 or 8/11/2024. The DON stated the UA lab results were sent to the NP and depending on the reasoning for the UA, they would give an order for the second one. She stated typically if a UA comes back contaminated the physician would order a straight cath. She stated on 8/11/2024 LVN B had documented Lab stated prior urine specimen was contaminated. Urine specimen obtained via straight cath for lab. Resident tolerated procedure without difficulty. The DON stated she did not see any documentation from LVN B communicating with the physician. The DON stated she was not seeing an order or that LVN B received an order for the UA repeat with a straight cath. The DON stated she never spoke to Resident #1 but had been made aware of the resident feeling uncomfortable during the procedure. She stated at that time Resident #1 was already at the hospital. She stated she was not aware there was a problem until now. She stated that was not what she expects of her nurses, and she did not know if the night staff needed to be educated on the proper procedure. She stated night staff did not typically do those kinds of things and that those UA collections were usually done on the day shift. The DON stated the 2-10pm shift should have called the physician and gotten new orders. She stated she did not see any documentation on notifying the physician. The DON stated it was not typical for UA straight caths to be performed at 3am. She stated the residents were asleep and doing a procedure while they were asleep was not okay and they were not clear on what was going on. She stated the procedure should have been done when the order was given or obtained. The DON stated there should have been progress notes, and all orders should have been implemented and documented for the date and time received. During an interview with the ADM on 9/4/2024 at 4:03pm, she stated Resident #1 had spoken to her on 8/12/24 about a procedure that had been performed on 8/11/2024. She stated Resident #1 had expressed feeling as if she had been raped. The ADM stated she explained to Resident #1 that the catheter went into her urethra (hollow tube that lets urine, a waste product, leave the body). ADM stated Resident #1 had expressed not wanting a straight catheter done. She stated she told Resident #1 she would report the incident to the state, and a skin assessment was performed. She stated the skin assessment did not reveal anything that looked like that to us so we sent to the hospital and asked for a rape kit. The ADM stated the hospital did not perform a rape kit as Resident #1 had no vaginal contact done. She stated she spoke to LVN B, and she had stated it had been passed down in report that the previous urine sample had been contaminated and they needed a recollection. She stated RN D told LVN B that there was a new order for a UA to be repeated. ADM stated CNA A and LVN B both went into Resident #1's room to perform the straight catheter. ADM stated both staff members stated that Resident #1 was awake and that LVN B had explained what she was doing to Resident #1. The ADM stated CNA A told her Resident #1 did say ouch for a second and then LVN B was done with the procedure. ADM stated CNA A did not see Resident #1 have an issue with the procedure. The ADM stated RN D had reached out to FNP for the UA order after he received the lab report stating the prior UA had been contaminated. The ADM stated consent for procedures such as straight catheters required a physician order and the consent was usually obtained verbally from the residents. The ADM stated LVN B was just trying to get the UA recollection done at 3am. She stated Resident #1 was pretty grateful that they had gotten the UTI and been able to treat it. The ADM stated it was very clear from the two staff that the resident was alert prior to performing the procedure. She stated staff communicate with physicians by phone and sometimes they come in person to give orders. She stated she would have to find out why the standing orders were delayed and not done on admission. She stated ideally staff was to put in the orders on the progress notes and pass it on in report. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN D on 9/4/2024 at 4:17pm, he stated he had received the lab report of the contaminated urine sample on 8/10/24. He stated it had been a busy shift so at the end of the shift he told the oncoming nurse, LVN B, that he had not had time to report the lab and if she would be able to follow up on it. He stated he asked her to notify the FNP about the contaminated UA. RN D stated he never spoke to the FNP on 8/10/24 and delegated it to LVN B. He stated he believed he collected the first UA sample that came back contaminated on 8/10/2024. He stated Resident #1 had been complaining of burning when urinating and discomfort, so he had notified the FNP on 8/9/24. He stated at that same time he noticed the admitting labs had not been completed and the FNP stated okay, so he went ahead and did the UA. RN D stated Resident #1 was very modest and did not like the male nurses to assist her. He stated she was adamant that she uses the urine collection hat as that was how they usually collected her urine sample. RN D stated in his experience the urine collection hat often results in an anomaly. He stated he told Resident #1 if the sample came back contaminated, they may have to do a straight cath. He stated Resident #1 said okay and agreed at that time, but he did not think too much about it. He stated he did not remember if he had put a note in about her having the urinary discomfort. He stated the nurse who admits the residents was responsible for initiating the admission labs. He stated all communication should be documented in the progress notes, to protect themselves, especially if it was a new order. He stated if he had reported the contaminated lab to the FNP, they probably would have said to do a straight cath. He stated if he could not get a hold of the FNP, he would have waited until he received an order. He stated he would not go past his scope of practice. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 9/5/2024 at 12:25 AM , she stated she arrived at the facility on 8/10/24 at approximately 9:45pm. She stated she got to Hall 3 at around 10pm. LVN B stated she received report from who she believes was RN D. LVN B stated According to my recollection he (RN D) told me the urine had come back contaminated and we needed to collect another specimen. I remember telling him that she was incontinent at night, and he said yea that's and I believe .it's been a while we probably talked about cathing (a procedure that involves inserting a tube into the bladder to drain urine or inject liquids). You know how it is, you do things and then get to the next. I believe during the day she was continent but at night she is incontinent. I'm not positive if we talked about cathing. I remember seeing the lab slip saying that it was contaminated I don't remember seeing anything written on it. I don't remember seeing an order for recollection. I don't remember if he mentioned if he did or did not speak to anyone about the lab. I would think probably but I can't guarantee that. She stated she had told CNA A that they would have to collect a urine specimen and to be notified of the next time she was going to provide care and they could do it all together. LVN B stated lab normally comes at 5 o'clock but she did not remember what time they went into Resident #1's room. She stated she explained to Resident #1 that they were in there to do a straight cath for a specimen. She stated Resident #1 told her she had already given one and LVN B told her that urine had been contaminated and they needed another specimen. LVN B stated she did not remember Resident #1 having any other questions. She stated she told her she would be putting a little tube in her to get the specimen. LVN B stated CNA A was in the room to help her and Resident #1 because it makes the process easier. LVN B stated Resident #1 said ouch but that it was not uncommon. She stated she stopped for a second and asked if she was okay and Resident #1 said yeah. LVN B stated she proceeded with the procedure and that was the end of that. She stated Resident #1 did not really say anything and she was cooperative during the procedure. She stated Resident #1 did not say anything after she explained the procedure to her. LVN B stated Resident #1 was cooperative during the procedure and had allowed her to do the precleaning and spread her legs for her to do the insertion. LVN B stated she walked Resident #1 through the procedure. LVN B stated again she did not remember Resident #1 saying anything after she explained the procedure. LVN B stated she was prompted to do the UA straight cath because Resident #1 was incontinent, and she already had one contaminated attempt. LVN B stated Resident #1 had been symptomatic, and she had complained of not feeling well . LVN B stated Resident #1 had lab work done as well, and she believed they did the lab work when they did the first UA. She stated the facility did admission labs when residents first come in. LVN B stated she never gave Resident #1 the option to use a hat for UA collection and she never asked Resident #1. LVN B stated she did not ask Resident #1 if she wanted to use a hat to give a sample because she was incontinent at night. She stated part of the consent was verbal and part of it was demeanor. She stated Resident #1 was responding to what she was asking her to do and did not state I don't want to do this. She stated she did not know if residents had to say the exact words I agree, or I refuse. She stated If they don't agree but they cooperate .I recall her saying okay and being aware of what we were doing. If she had said don't do that, I wouldn't have done it. I believe she consented. LVN B stated she believes Resident #1 was fully awake during the procedure and she was cooperative by following prompts and spreading her legs or scooting her bottom as needed. LVN B stated later that night when she went to give Resident #1 her medications, she stated Resident #1 asked her why she had to do that to her, and she explained to Resident #1 that the specimen had been contaminated and they needed another sample. She stated Resident #1 said okay. LVN B stated she was under the impression there were UA recollection orders from the report given by RN D. She stated she remembers discussing the sample contamination and getting another specimen with RN D. She stated they were supposed to receive orders before performing a procedure like that. LVN B stated a typical order would state collect UA via straight cath and if it did not say straight cath she would clarify with the physician. LVN B stated she was trained to verify orders before performing a procedure. LVN B stated I don't guess I did that day. I do not remember seeing any physician orders, I don't recall if RN D told me he had notified the physician or if he had gotten an order. I just knew that I needed to collect a UA through the conversation with RN D. LVN B stated the facility liked for night shift to collect the urine specimens unless it was a stat situation but for the most part, routine admission labs were done by the night shift. She stated she normally lets the CNAs know if a UA had to be collected so she can do it during their next peri care or if they were requesting pain medication, or something

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal documentation by RN D, for Resident #1 reporting pain and discomfort with urination and requesting to be tested for a UTI on 8/9/24 or the days prior to. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal communication between staff and physician for notification of Resident #1's change in condition on 8/9/2024. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal LVN B or RN D's communication with physician regarding a contaminated urine analysis and it did not reveal documentation of a phone order obtained for recollection by straight cath, from the physician or by the nurse who obtained the order. Record review of Resident #1's EMR physician orders did not reveal documentation for an order for a UA repeat and method of collection on 8/10/2024 or 8/11/2024. Record review of Resident #1's nurses notes dated 8/04/24- 9/4/2024 did not reveal LVN B's documentation of Resident #1 being upset after the straight catheter procedure on 8/11/2024. Record Review of facility policy titled Documentation last revised on April 23, 2023, revealed, Policy: Documentation of the clinical assessment of the resident will be recorded in accordance with state specific regulations, other regulatory bodies as indicated and the practice guidelines in the EHR . Procedure: The IDT (a group of people with different areas of expertise who work together to achieve a common goal) will be responsible for recording care and treatment, observations, and assessments and other appropriate entries in the resident clinical record according to professional practice guidelines . 3. Resident Data Collection: all data collection tools and assessments. Routine, Event, Change of Condition . 7. Activities: Data required by activities will trigger per regulation and/or facility policy . C. Observation Data . .M. Event Data Collection: required documentation for individualized events or needs of the patient, must be manually triggered under Assessment Schedule . I. Grievance . .N. Change of Condition: Physician/NP/PA communication progress note for new conditions, signs, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and other changes of condition. a. Completed prior to notifying Physician/NP/PA of change. b. Notification notes and orders entered at the end of Request .